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Homanen, Riikka Mari Petronella

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Reproducing whiteness and enacting kin in the Nordic context of transnational egg donation: matching donors with cross-border traveller recipients in Finland

Riikka Homanen

Sociology, Faculty of Social Sciences, University of Helsinki, Unioninkatu 35, 00014, Helsinki, Finland

Abstract

The multimillion-euro fertility industry increasingly tailors its treatments to infertile people who are willing to travel across national borders for treatments inaccessible at home, especially reproductive tissue donor treatments. Finland is the Nordic destination for access to donor eggs, particularly for Swedes and Norwegians hoping for a donor match that will achieve a child of phenotypically plausible biological descent. Finns are seen as Nordic kin, and the inheritability of "Nordicness" is reinforced at clinics. Drawing on ethnographic material from three fertility clinics in Finland during 2015–2017, this article discusses how Nordic relatedness and whiteness are enacted in the practices of matching of donors with recipient parents. The analysis shows a selective and exclusionary rationale to matching built around whiteness: matches between donors with dark skin tone and recipients with fair skin tone are rejected, but a match of a donor with fair skin and recipients with dark skin may be made. Within the context of transnational egg donation, the whiteness or Nordicness of Finns is not questioned as it has been in other historical circumstances. Even the establishment of a state donor register offers a guarantee of kin-ness, especially non-Russian kin-ness. It is concluded that the logics of matching protect the "purity" of whiteness but not browness or blackness, enacting Nordic(kin)ness in ways that are part of broader intra-European histories of racism and post-socialist Othering.

Keywords: Finland, Transnational egg donation, Assisted reproductive technology, Donor matching, Whiteness, Kinship, Nordic countries, Ethnographic methods

Introduction

Markets for reproductive healthcare have become increasingly transnational in that people increasingly travel across state borders to access care (e.g. Franklin, 2011; Inhorn, 2010; Thompson, 2011). The multimillion-euro fertility industry increasingly tailors its treatments to infertile people who are willing to travel to receive treatments unavailable or inaccessible at home because of legal barriers, long waiting lists and high prices (ESHRE, 2010). Gamete/embryo donation and gestational surrogacy are part of this trend (Franklin, 2011; Van Hoof et al., 2015; Vora and Iyengar, 2017; Waldby, 2012). People travel mostly to access donor tissue and treatments. Key destinations include Spain, the Czech Republic and South Africa for egg donation; Denmark for sperm; Mexico, the US, and until recently India for commercial surrogacy (Adrian, 2016; Deomampo, 2016; Gunnarsson Payne, 2016; Kroløkke, 2017; Namberger, 2017; Smietana, 2017; Speier, 2016).

This transnational traffic or "reproflows" (Inhorn, 2010) migrates along historical paths of domination and commerce (Bergmann, 2011; Deomampo, 2016; Thompson, 2011; Vora and Iyengar, 2017). Previous research argues that cross-border travel for reproductive care reproduces global inequalities, colonial legacies and exclusions in terms of gender, economy and race (Vora and Iyengar, 2017). Only a few can become global biocitizens, exiting and entering regulatory systems, while others – especially women – are reproduced as providers of resources and reproductive labour (Franklin, 2011; Namberger, 2017; Waldby, 2012). Moreover, historically racialized notions of the world are also at work when people choose destinations for their reproductive journeys (Kroløkke, 2017; Speier, 2016).

Studies of traffic to/from key destinations show that travellers typically seek reproductive tissue donation that will assure phenotypic resemblance with the infertile intended parent (e.g. Smietana, 2017; Speier, 2016; Thompson, 2011). That is, they wish to be matched with a donor that shares their ethno-racial(ized) background and personal qualities. Such matching allows the intended parents to pass as the genetic parents in public, and thus to be discreet regarding donor use. In many countries, clinics and brokers involved in gamete donation bolster the creation of an ethno-racially matching nuclear family (Deomampo, 2016; Speier, 2016; Thompson, 2009). It is believed that the donor's ethno-racial(ized) characteristics can be genetically passed on to children born from donor treatments.

The notion of matching intended parents with donors derives from adoption practices (e.g. Haimes and Timms, 1985), and appears to have been embraced uncritically in fertility treatment practices. Studies show how policy and practice of both adoption and donor fertility treatments aim to match intended parents with children/donors on the basis of phenotypical resemblance and/or other personal characteristics (Andersson, 2016; Deomampo, 2016; Speier, 2016; Thompson, 2009). Policymakers and medical professionals have even regarded the lack of physical or other personal resemblance as a risk to the successful attachment between parents and child (Andersson, 2016; Thompson, 2009; cf. Government Bill HE 3/2006). This risk argument reproduces the ideal of a solid base of genetic kinship. Indeed, according to Thompson (2009, p.144), matching has kept "assisted reproductive technologies (ART) as 'natural' as possible, and aid[ed] families in domestic decisions about disclosure regarding donor use".

Racial or ethnic proximity are not clear or stable categories; nor is their relation to genetics at all clear-cut. I align myself with research that understands race and ethnicity as social categories enacted in historically and culturally situated practices (Vuolajärvi, 2014; Whitmarsh and Jones, 2010). People are differentiated, and these differences are stabilized into categories of race and ethnicity: people are racialized (Mulinari et al., 2009, p.4). Linking race to biology has a long history that according to writers legitimized colonialism (Thompson, 2006; Whitmarsh and Jones, 2010). The

scientific quest to define human characteristics on the basis of biological race has come a long way since the heyday of biological race theories and eugenics at turn of the 20th century, which relied heavily on colonial attitudes while making classifications on the basis of observed appearances and behaviours. These racist theories were falsified even before the advent of today's genomics and population genetics, which show how impossible it is to distinguish between the biological and the cultural in "race" (Kemiläinen, 1998; Oikkonen, 2017; Thompson, 2006).

Yet the concept and practice of race persist. That is why it is important to continue the discussion in terms of race and not just its more politically neutral cultural counterpart, ethnicity. For example, biological racialization is often part of the transnational and domestic stratification of gamete and embryo markets (Ong and Collier, 2005; Thompson, 2006). While East European populations are rarely thought of as kin nationals by North Americans or Nordics, countries such as the Czech Republic and Estonia are destinations for white travellers from those regions seeking access to donor eggs to ensure racial stability in their families (Gunnarsson Payne, 2016; Speier, 2016). This situation reproduces whiteness by "creating and sustaining geographies of relatedness that both depend on and displace the significance of blood relations" (Nash, 2003, p.181).

Drawing on my research using ethnographic material collected from three infertility clinics, this article discusses Finland as a destination for donor eggs, mainly for other Nordic travellers. By analysing how healthcare personnel – in collaboration with intended parents – match donors with recipients, I show how (Nordic) whiteness is reproduced and national relatedness/kin enacted in everyday care practices. The Finnish case reveals hierarchies within understandings and practices of whiteness in Nordic countries, and how it is possible to "climb" those hierarchies. Racial categories have internal hierarchies, and their borders shift over time. Some people are perceived as more securely white – the racial category that carries the greatest sociocultural privilege – than others (Ahmed, 2007; Dyer, 1997; Vuolajärvi, 2014). Historically, Finns have not always been considered true Europeans or part of the "white race", but have been spoken of as a dark people of Asian and

Mongolian origin – even though Finns are among the world's blondest populations (Kemiläinen, 1998; Vuolajärvi, 2014). Within the context of transnational egg donation, however, it seems that Finnish genetic material is good enough to be included in the Nordic kin(d). Before analysing this in detail, I present a short description of my project and methodology.

Researching the everyday care practices of enacting whiteness and kin

This article is part of a bigger research project concerned with the constitution of interconnected social relations, such as kin, class, gender and race/ethnicity, in reproductive healthcare practices in the context of healthcare marketization. As the markets for reproductive healthcare have become more transnational, the research has also included cross-border travel for care. During fieldwork it soon became clear that the matching of cross-border recipients and local donors was constitutive of national and ethnic kin and whiteness. Thus, I decided to focus on matching more deeply.

To look directly at care processes and practices, I used ethnographic methods (Harbers et al., 2002). After obtaining formal permission for fieldwork from the Ethics Committee for the Social Sciences and Humanities at University of Tampere, and consent from healthcare personnel, I conducted approximately two months' fieldwork between late spring 2015 and spring 2017 at three different clinics. Consent to participate was sought separately from all the intended parents.

By choosing three clinics I aimed to capture a diversity of care practices that could not be explained away by, for instance, specific clinics' or professionals' styles. At the time of my fieldwork, ten private (and nine public) clinics in Finland offered the in vitro fertilization (IVF) required in egg donation treatments. A head doctor I talked to at the beginning of my project alerted me to these three particular clinics as those that received the most cross-border travellers. The clinics were situated in three big cities in Finland, all easily reached from abroad by air, land and sea.

Fieldwork was conducted in periods from a few days to two weeks at a time, depending on the clinics' wishes. After two months I concluded the fieldwork, as it seemed that my observations and video

recordings had covered all the different activities, settings and temporal cycles involved in fertility treatment care. While two months is a relatively short period in research influenced by ethnographic methodology, through video recordings I was able to collect a large amount of data-intensive material relatively quickly.

The material comprises videotapes from appointments (63 videos) and procedures (42). Appointments include initial interviews, planning of the care cycle, and ultrasound screenings to determine the development of the endometrium and/or ovarian follicles with doctors. Nurses and embryologists also meet the intended parents: nurses give instructions on taking medication and preparing for procedures, and embryologists discuss embryo development and selection. The egg donation treatment coordinator – usually one of the most experienced nurses – is primarily in charge of donor/recipient matching, correspondence with recipients, and treatment contracts. There are usually one or two coordinators per clinic. The procedures comprise inseminations, egg retrievals and embryo transfers with doctors, nurses and embryologists. Appointments vary from 60–90 minutes for initial interviews to 15–20 minutes for ultrasound screenings and instructions. Procedures take around 15–30 minutes. Of all my video recordings, 23 were of appointments and procedures with fertility travellers who were not Finnish residents.

Observations were also conducted in meeting rooms, clinic common areas, and the IVF laboratory where all the reproductive cells were stored, oocytes fertilized and embryos cultured. I also collected interview data from 18 healthcare professionals working at the clinics, including doctors, nurses, embryologists and coordinators, to cover their experience-based knowledge of doing fertility treatments. Intended parents were not interviewed – an obvious shortcoming of the study. Their voices, however, can be heard in my fieldnotes on my chats with them and video recordings of appointments.

Handouts distributed to intended parents, and local and nationwide care guideline materials, were also collected. The professionals identified this material as documents they used in their work.

The videos and interviews were fully transcribed. I also wrote fieldnotes on the video recordings to account for non-verbal activities. As is common in ethnographic inquiries, analysis of the material involved ongoing reframing through knowledge produced collaboratively with participants (Holmes and Marcus, 2008).

This enabled me to examine how national relatedness like whiteness/race is realized and challenged in situational *practices* that are (re)created by a multitude of actors. Western practices and notions of kinship, which prioritize biological connections and genetic relatedness through heterosexual sex and pregnancy, have been repeatedly contested, reformulated and also reinforced by ARTs, reproductive tourism and the marketization of ART (Franklin, 2001, pp.311–312; Thompson, 2005). New and transgressive third-reproductive-party technologies, including donor tissue treatments, constantly bring about new ways of not just perceiving kinship but also becoming related – juridically, socially, affectively and biologically (Franklin, 2013). Within the context of transnational reproductive tissue donation, this means not only becoming related as a family at an individual level, but also becoming related as nations and as belonging to a nation of peoples. Hence in my analysis kinship – like race – is understood as enacted in everyday socio-material practices where biology and sociality, nature and nurture, are connected in specific ways according to historical cultural, political and economic contexts (e.g. Franklin, 2013; Franklin and McKinnon, 2001; Kroløkke et al., 2016).

Egg donation and fertility travel in Finland

In this section I give an overview of egg donation and fertility travel in Finland today: the regulations, the local market, the political economies of that market, and the reproflows of non-resident travellers. Because only very limited information, statistical or otherwise, exists on egg donation and fertility travel in Finland, I use knowledge gained from my own fieldwork to draw a picture of the current situation.

The legislation regulating infertility treatments in general and egg donation in particular in Finland dates back to 2006, when the Act on Assisted Fertility Treatments (1237/2006) was passed. Previously, treatments had been self-regulated by professionals and their associations. The law legalized gamete donations and fertility treatments for single women and, in effect, lesbian couples, but criminalized surrogacy, and banned anonymous donation and any remuneration of gamete donors. A state donor identity register with an identity release system was established. All gamete and embryo donors since 2007 have been registered, and children born as a result of donor-ART may on request receive identity information about the donor after turning 18. The intended parents are not at any point entitled to this information.

The register was originally built on arguments about children's rights. Children born as a result of donor treatments were seen as having the right to know their genetic parents (Government Bill HE 3/2006; Grand Committee Report 1/2006; see also Eriksson, 2017, pp.130–131). It has been claimed that state registers, identity release systems and the prohibition of anonymous gamete donation are becoming common internationally (Hudson et al., 2011). For example, this is the case in Sweden, Norway, Austria, Switzerland, the UK and several Australian states (Blyth and Frith, 2015; Blyth et al., 2004). Within the global context of ART regulation, the Finnish policy follows these trends. Finland has also been described as rather permissive (Eriksson, 2017). Indeed, it is so compared with other Nordic countries; I return to this below.

With regard to matching donors with recipients, the law states that "the attending physician shall select gametes whose donor resembles in appearance the respective parent of the child to be born, unless otherwise requested by the person receiving treatment" (Act on Assisted Fertility Treatments 1237/2006, Section 5(3)). Appearance is broken down into five characteristics on which information can legally be collected for matching: "colour of the donor's skin, eyes and hair as well as the donor's height and ethnic origin". These five characteristics can be revealed to recipients (Act on Assisted

Fertility Treatments 1237/2006, Section 15). The Act assumes that these mostly ethno-racially associated qualities of the donor will be carried in the genetic code of the egg/sperm into the child.

Egg donation in Finland is largely a private enterprise, centred in a few large chains of clinics with links to international enterprises. Although this treatment is not state-funded or state-provided, Finnish residents aged under 43 are eligible for some reimbursement from the Social Insurance Institution. As use of donor eggs usually follows many rounds of IVF with one's own eggs, the women treated at these clinics tend to be older than those treated with their own eggs, unless they have been diagnosed with conditions that prevent them from using their own oocytes. Private clinics are also the service providers for cross-border travellers coming to Finland.

Finland combines a state-funded Nordic welfare system with a growing commercial care sector. The policy discourse of the centrality of economic competitiveness has been particularly strong in Finland since the 1990s (Mulinari et al., 2009). The Finnish government works in conjunction with the private sector to attract medical tourists, and public-private partnerships play a vital role in service provision. For example, FinlandCare, a mediator organization coordinating the sale of care services abroad, was established as a collaboration between government agencies and private companies. Flexible arrangements have also been established to allow doctors whose main jobs are in the public sector to also work as private practitioners. The wide network of private hospitals and clinics in Finland – compared with Sweden, for example – is thanks to these developments, rather than to any unusually strong pronatalist policy.

The clinics themselves advertise their services to potential foreign customers, mainly through websites and Google optimization. Many people are also referred to the clinics by collaborating physicians, especially in other Nordic countries. Donors are recruited through advertisements, and various events are also organized, for example in local universities. Recruitment is successful: during my fieldwork there was no waiting list for donor oocytes.

Within the Nordic region, the geographical and ethno-cultural region including Finland, Sweden, Norway, Denmark and Iceland, Finland is the destination for travellers seeking donor eggs. In 2016, 480 cycles of treatment were performed on non-Finnish residents. Of these, 370 were performed with donor gametes, and the overall number of donated eggs during that year was 314 (309 in 2015) (National Institute of Health and Welfare, 2017). As it is a rule of conduct among practitioners in Finland that only one (or in rare cases two) embryo(s) can be transferred simultaneously (Treatment protocols of clinic ABC, 2016), the number of cycles with donor eggs per year is likely around 300. Many Finnish donor eggs go to fertility travellers: according to my interviews and informal chats with clinic staff, cross-border fertility travellers almost without exception come for donor egg treatments, not for treatments using donor sperm or their own gametes. The travellers are mostly from other Nordic countries, specifically Sweden and Norway, but also to a lesser degree from places such as Germany, Austria and Switzerland. Russia is also the country of origin of a relatively large group of travellers; curiously, however, Russians do not travel for donor egg treatments, but use their own gametes, according to professionals.

For reproductive migrants to Finland, the biggest push factor appears to be restrictive laws and policies. In Germany, Norway, and until very recently Austria, egg donation is completely forbidden (see also Bergmann, 2011; Gunnarsson Payne, 2016). In Sweden oocyte donation is allowed, but the problem is a restrictive service system. Most of the clinics that offer donor egg IVF work in connection with public hospitals, where the age limit for women is 40. By the time physicians suggest the use of donor eggs, women are usually over 40. Also the waiting time for donor egg treatments is rather long, because of the small number of private clinics. The service is de facto unavailable to many people in Sweden.

For Nordic travellers, Finland is also conveniently close. More often than not, clinic personnel speak Scandinavian languages. Nordic people also tend to perceive many cultural commonalities among Nordic countries, especially in the systems, standards and ethics of care (Magnussen et al., 2009).

Finland is not the only destination in Europe for donor eggs, and certainly not the most affordable. However, it is not one of the most expensive either. A cycle of donor egg treatments costs around €7,000–7,500 (Clinics ABC websites, 2017).

The trajectory of care for fertility travellers

Before a care cycle (or series of cycles) can start, all the patient candidates are assessed to determine their eligibility. Some clinics refuse "full donation" (i.e. the use of both a donor egg and donor sperm in the same treatment), on the grounds that lack of genetic kinship would be too "complicated" psychologically for the intended parents and child. Donor egg treatment for single women and lesbian couples is therefore refused, as such treatment for these patient groups would involve full donation. Hence people travelling to Finland for donor eggs are mostly heterosexual couples. Towards the end of my fieldwork, however, full donation was increasingly offered to everyone – especially to regular clients who had been going to the clinic for a while.

Once the patients have been granted access, the trajectory of care for cross-border travellers is different from that of Finnish residents, in that the former see clinic staff less often. Often the couple meets clinic staff only once for the initial interview and/or planning of the care cycle, and then for the giving of the sperm sample and transfer of the fertilized embryo. Before the treatment cycle can start, the couples do meet the treatment coordinator to discuss their donor preferences and sign treatment contracts, after which the coordinator starts looking for a matching donor. While the coordinator is in charge of the matching, other professionals may be involved in discussing potential matches, and finally doctors makes the formal decision.

When a match that pleases the recipients is found, the menstrual cycles of the donor and intended mother are synchronised. Then the donor's ovaries are hyperstimulated and the recipient's endometrium prepared for embryo transfer with medication. The treatment protocol includes two ultrasound screenings to determine the development of the recipient's endometrium and the optimal

date for the transfer (Treatment protocols of Clinics ABC, 2016). Screenings are often performed in the country of origin. According to the professionals, despite the lack of face-to-face encounters, the client-professional relationship tends to become even deeper than with locals. They say this is because the travellers keep close track of the matching process and are eager to discuss all the care choices.

Salience of skin tone and/to ethnicity in matching

Finnish legislation directs medical professionals to match donors to recipients on the basis of skin tone, eye colour, hair colour, height and ethnic origin (Act on Assisted Fertility Treatments 1237/2006, Section 15). These are also the only characteristics about which recipients can make requests and medical professionals can share information. The recipients are also informed about the donors' age range (18–35 in my fieldwork clinics), and about the strict health criteria for donors. For example, for donors to qualify, several genetic disease categories need to be ruled out.

According to my observations the coordinators at my fieldwork clinics maintained Excel spreadsheets of donors and recipient women in accord with the five matching characteristics. Often there was also a field for additional information, including the number of pregnancies achieved with the oocytes of the donor in question and any limits she might have set on the use of her oocytes, such as not giving them to non-Finnish residents. Recipients' requests concerning the five characteristics were also recorded on the spreadsheets. The coordinators told me that for the most part matching was about finding donors sufficiently close to recipients' wishes regarding the five characteristics. Usually this meant a donor resembling the intended recipient mother as closely as possible, as is evident in the following extract from an interview with a coordinator.

> Q: What kind of requests are common then?
>
> A: Well of course that she [donor] resembles as closely as possibly the partner if the question is about a couple. And in a way it is understandable in that one rather wants, wants that she is close to one's own characteristics.

(Interview with coordinator 1, clinic A)

Recipients' preferences for the donor to be closely matched in physical appearance to the intended mother can be seen in the following snapshot from a video recording. This was at an appointment with the same coordinator to discuss a potential match.

> A Norwegian couple has come to sign their treatment contract and talk about a potential match the coordinator has found for them. The coordinator prints out the contract and sits down to talk to them in her office. She explains to the couple: "If it is okay [with you] to start, we have already a possible donor for you, and we could start as planned. Well, after your period […] This donor is 162 centimetres [tall] and she has blue eyes and blond hair so very similar to you, only a little bit shorter but I think it is okay." The woman looks at her partner and responds by saying, "Yeah, that is okay. You [partner] are tall enough." Her partner laughs and nods. The coordinator laughs and confirms: "Yes, you are tall enough."
>
> (Videotape of appointment between coordinator 1 and Norwegian couple, clinic A)

Matching is not an exact science, and as in this snapshot, the complexity of inheritability of physical characteristics is realized to some extent by professionals and recipients alike. It is implied that the genes of the tall intended father might "make up" for the donor's shortness.

I was also told that sometimes the task of matching was very easy: upon meeting a new recipient couple one might instantly think of a particular donor. This was described to me as a feeling about the couple and the donor, an impression of their gestalt that could not entirely be reduced to the five characteristics upon which matching was formally based. Furthermore, if a couple had had many unsuccessful transfers with donor oocytes, a new donor whose donations had previously resulted in pregnancy would be chosen.

The legislation regulating egg donation (Act on Assisted Fertility Treatments 1237/2006) in principle allows intended parents to request a donor who does not "resemble in appearance the respective parent" (Section 5(3)). When I asked coordinators and doctors about taking such requests into account, I often received confused looks, and comments such as "we only have Finnish donor girls [implying a "Finnish look"] here" or "that has never happened." It was so taken for granted that recipients wanted their donor to match them as closely as possible that asking about it was a bit absurd.

When I kept pushing with hypothetical scenarios of recipients wanting characteristics different from their own, I was straightforwardly told in relation to *skin tone and ethnic origin* by one clinic coordinator that "we do not mix races here." I asked why that was:

> A: So we just do not mix races. Only when, well, we have had a quite dark-skinned lady and of course a few dark donors too. But we aim not to make a mess of races.
>
> Q: Is it because it is not seen as in the best interest of the child or what is it…?
>
> A: I suppose, yes, part of it could be. Of course if you think about these recipient couples, we have treated those in which the wife has been white and the husband has been dark-skinned. They are of course told that we don't have a dark-skinned donor. But if both [intended parents] were dark-skinned, and if we did not have a dark-skinned donor at that moment, then Jyrki [the head doctor] will, Jyrki gets a lot of these patients [i.e. cross-border travellers], he says to them that you should contact another clinic. I suppose it is that is it then so striking, that difference. So that is how we have operated.
>
> (Interview with coordinator, clinic B)

As the coordinator did not really answer my open question earlier about why and how they decided not to "mix races", I asked if it was because they thought different skin tone in a child would not be in the child's best interest – a common argument for treatment decisions. As it turned out, it was about

the fact that the professionals involved regarded participation in what they called "mixing races" by selecting a white donor for dark-skinned recipients as unacceptable in itself. As a result of that kind of mix-and-match, a child of *striking difference* would be born, and that was something the clinic did not want to be part of. However, if the infertile mother of the intended parents was "white" the clinic would agree to treat the couple as long as it was their informed choice (because there were no donors with darker skin tones).

The other two clinics had treated couples with dark skin tones with donor eggs retrieved from white Finnish women. I discussed such a case with a coordinator:

> A: We have this one that just made a positive pregnancy test that is almost black, from Norway, but she wanted a Finnish donor.
>
> Q: Yes, I have understood that one can decide.
>
> A: No [that's not it], it is then like when one's own husband's sperm is used then the child will be so-called mixed race. So they will not be totally black but dark because the sperm is from a black man. I think we have had a few of these couples that have wanted a Finnish donor. Then we have had a few of these with Arab origin. We have a few brown-eyed and -haired [donor] girls so we have chosen of course those girls for them. But it is also so that when the husband's sperm is used, the husband is often very dark and the darkness is a hereditary characteristic. Even if one [i.e. donor] is Finnish by colour, the children will be darker.
>
> (Interview with coordinator 1, clinic A)

Again, it is emphasized here that the couples in question wanted a "Finnish donor". However, when I suggest that patients can decide about donor skin tone, the coordinator quickly rejects my suggestion, and explains that matching intended parents with darker skin tones with a white donor is acceptable because it creates some phenotypic credibility of biological decent, as dark skin tone is

believed to be more heritable than light skin tone. This implies that no such credibility would arise with a dark-skinned donor and white intended parents, who therefore would not get to choose such a thing. Thus, although there may ideally be flexibility in the matching of skin tones, in practice it only applies to intended parents who are considered dark-skinned. It is disregarded that the inheritability of ethno-racial(ized) qualities is unpredictable, and that there is a history of lighter-skinned children being born to darker-skinned parents (Thompson, 2005, 2009).

The interview extract above also reveals that the clinic in question has been selecting brown-eyed and -haired donors for recipients with darker skin tone, with the goal of a child that better resembles the intended parents' ethno-racial(ized) group. This suggests that the clinic enacts brownness/blackness by selecting characteristics from other ethno-racial marking systems: hair and eye colour. Thus the practices of matching realize that perceiving skin tone in a socially relevant way always involves its intersection with other ethno-racialized attributes (Thompson, 2009).

With regard to height and eye/hair colour alone, however, I heard stories concerning the difficulty of pleasing intended recipient parents. The clinics' staff complained that some cross-border traveller recipient women would not accept donor candidates who were only a few centimetres shorter/taller than themselves, or who had light brown rather than brown hair or blue rather than grey eyes. Here, the professionals questioned the passing on of such precise physical attributes from donor to offspring. Interestingly, skin tone (or ethnicity) never came up in this context, reaffirming my impression of the salience of skin tone to whiteness, and the clear correlation made with social categories of race and ethnicity at the clinics.

Scandinavian/Nordic kin ethnicity and race

In the previous section I described, among other things, how professionals treat white skin tone as a clear indication of race and ethnicity. In this and the following section, I show how white Finns, Swedes and Norwegians are enacted national ethno-cultural and biological-racial kin(d). I start with

a quotation from an interview with an embryologist. We were talking about matches that had been made at her clinic between donors and recipients with different ethnic backgrounds and skin colour. Before moving on to a different subject, she concluded:

> But there is just more use for Scandinavians [gametes]. Scandinavians want to use Scandinavians.
>
> (Interview with embryologist 2, clinic B)

This quotation conflates Scandinavian and Nordic ethnicity. This is not uncommon in general, and I often heard the terms used interchangeably at clinics. However, Scandinavia is characterized by a shared North Germanic ethno-cultural heritage, and comprises Sweden, Norway and Denmark – not Finland. It differs from the Nordic region, another shared cultural area, comprising Finland, Sweden, Norway, Denmark and Iceland.

According to my observations, ethnicity was also equated with nationality, as seen in the following interview when I asked a coordinator what "ethnic origin" meant in matching:

> A: Well it, I think it is a bit funny like so that there are two things that we tell [the recipients], well, Scandinavian and Finnish. They do know that all our donors are Finnish.
>
> (Interview with coordinator 2, clinic A)

The use of "Nordic/Scandinavian" and Finnish together like this to characterize inheritable donor qualities is telling of underlying perceptions of ethnic kin nations. An association with old racial classification of the "Nordic race" as a "sub-race" of the Caucasian race was also evoked in an interview with a head doctor at one of the clinics. After I asked why she thought cross-border travellers came to Finland, she talked about how the clinic recommended a donor from the same "ethnic group". I used a study (Gunnarsson Payne, 2016) of Swedish women going to Estonia for

donor egg treatments to push the discussion further. I told her that in that study women did not want Russian donors because they regarded Estonian donors as ethnically closer to themselves than Russians. At this the head doctor expressed her surprise:

> A: But they [Estonians and Russians] have the same ethnic origin. We are all Caucasian, both Russians and Nordics and people from the Baltic.
>
> (Interview with head doctor, clinic A)

She went on to say that what intended parents usually wanted was Nordic donors. In conclusion, Finnish ethnic origin is translated into both, Nordic and Scandinavian, kin nationality and race, perceived as genetic difference or similarity (cf. Gunnarsson Payne, 2016, pp.38–39).

Guaranteeing Nordic(kin)ness

As described above, recipients' wishes are selectively taken into account in matching, and the suitability of donor candidates is negotiated with recipients. In this way matching is to some degree a collaborative project involving professionals and recipients. It also involves legislation that delimits what can be taken into account in matching. The legislation has also altered the practice of matching as a *practice of Othering* in terms of race/ethnicity/nationality through the deployment of a state register with an information release system.

Many recipient travellers I talked to mentioned the "Nordic look" or talked about how Swedes/Norwegians resemble each other. Professionals also pointed out that cross-border travellers liked the state register. Recipients confirmed this, as in the following snapshot from my fieldnotes:

> A Norwegian couple has come to the clinic for embryo transfer. After the transfer, I chat with them for a bit in the waiting room. I ask why they picked Finland as their destination to access donor eggs. The woman answers because "Finns do look like Norwegians" and "there is open donation here." I am puzzled by the term "open

> donation" and ask her to elaborate. She says she means there is a state register here, and continues by saying "the clinic knows the donor, the donor is truly known." I ask: "So that there are no unpleasant surprises…?" I had hereditary health conditions in mind, but did not mention it. The woman nods and repeats: "Us Norwegians and Finns look alike."
>
> (Fieldnotes, 23 August 2016, clinic C)

Picking a destination to access donor eggs according to an imaginary of ethnic resemblance suggests a strategy that diminishes ambiguity concerning the kin relationship between the receiving parent and hoped-for child (Thompson, 2005, p.146). References to the state register in this context, "to truly know the donor", hint at a perception of the register as a guarantor. The intended parents, however, will not actually know much about the donor. The register can only really work as a guarantee of traceability, and of the known characteristics: eye colour, hair colour, height, skin tone and ethnic origin.

A state register that was built on children's rights is hence in practice taken as a guarantor of the Nordic ethno-racial origin of the donors and thus the future offspring. When I discussed this with clinic staff, I was told that before the register cross-border travellers had been particularly concerned that the donors might be Russian. This has also been noted in studies of Nordic women travelling to Eastern Europe for egg donation: they refuse Russian donors and worry about Baltic donors on the basis of stereotypes of ethnic resemblance (Gunnarsson Payne, 2016; Bergmann, 2011).

Finns' ethno-racial origin as Nordic kin is not at all clear historically; nor have Finns always been perceived as properly white or European. Racial theories of Finns' Asian and Mongolian origin have maintained the view of Finns as dark- or yellow-skinned, brown-eyed, small, clumsy, less talented and less good-looking than true Scandinavians, despite Finland's history as part of Sweden (1150–1809) and Finns' constant migration and mixing with Swedes (Isaksson, 2001, p.263). While the

perception has slowly changed to see Finns as taller, blonder and bluer-eyed, unscientific popular notions of their "mysterious" Eastern origin have persisted (Kemiläinen, 1998, pp.273–275). This is perhaps partly also because Finland has historical links to Russia. Finland belonged to Russia in 1809–1917, and Russia has been of special political and economic interest to Finland as a neighbouring superpower.

For the reproductive purposes of Nordic cross-border travellers today, however, the practices of matching enact Finns as white Nordic kin. Professionals enforce this kin-ness by talking about "Finnish" and "Scandinavian/Nordic" donors to imply a certain white Nordic look. Furthermore, the clinics' websites are full of pictures of babies and women with fair phenotypic features, and it is stated that recipients are provided "with gametes of domestic origin" (Clinics websites, 2016).

Conclusions: protecting whiteness and reproducing post-socialism

In my inquiry into transnational egg donation in Finland – the first inquiry of its kind – I have found that Finland is the destination of choice for accessing donor eggs in the Nordic region. Swedish and Norwegian travellers are pulled to Finland by permissive legislation, relatively reasonable costs, geographical and cultural proximity, availability of care, and imaginaries of common Nordic whiteness and ethnicity.

In this article, I focused on the practices of matching traveller recipients and local egg donors. Matching involves multiple actors. The Finnish legislation gives formal guidelines on how matching should be done (cf. Almeling, 2011). Recipients can make requests about five physical characteristics – eye and hair colour, height, skin tone and ethnic origin – and can veto any donor candidate. Donor characteristics are also negotiated with recipients. It appears that often the shared goal of matching is "to bring about some kind of phenotypic 'plausibility'" in the sense of "legibility between the mother and the child of plausible biological descent" (Thompson, 2009, p.139).

Ethno-racial(ized) resemblance appears central to the achievement of this plausibility in matching practices. My study confirms previous findings (Deomampo, 2016; Speier, 2016; Thompson, 2009) on the salience of skin tone to whiteness, and on how correlations are made to social categories of race and ethnicity when medical professionals match donors with recipients.

Medical professionals are gatekeepers to (Nordic) whiteness. Through apparently biological reasoning, recipients with dark skin tones may be matched with donors with fair skin tones if they wish, but recipients with fair skin tones will not be matched with dark-skinned donors. This suggest an exclusionary historical rationale built around whiteness: protecting the "purity" of whiteness but not brownness or blackness (Whitmarsh and Jones, 2010). Having a fair-skinned ancestor does not necessarily make one fair-skinned, according to this reasoning. To reinforce the social relevance of this kind of matching, the clinics select donors with other qualities marked ethno-racially as black/brown. This is how whiteness, brownness and blackness – race – are reproduced at the clinics.

In this particular historical circumstance, the whiteness of Finns is not questioned as it has been in other circumstances (Isakson, 2001; Kemiläinen, 1998; Vuolajärvi, 2014). To apply Dyer's (1997, p.19) terms, under particular historical circumstance more people – Finns – have been admitted into whiteness "to unite people [of Finland, Sweden and Norway] across national cultural differences". Finns are strategically seen as Nordic and even Scandinavian kin, and clinics reinforce the inheritability of this "Nordicness", which involves notions of the "Nordic look". The establishment of a state donor identity register has been perceived as a guarantor of this kin-ness – especially of non-Russian kin-ness.

The tendency of national stereotypes to surface in these ways can be interpreted as part of broader intra-European histories of racism – as part of the racialized and post-colonial order of things. Prior studies show how ARTs have long been appropriated in economic and government policy as technologies of colonialism and nation (Bergmann, 2011; Deomampo, 2016; Kroløkke, 2017; Vora and Iyengar, 2017). In Nordic countries, and perhaps in Europe more broadly, this requires us to

recognize the similarities in the Othering processes of post-colonialism and post-socialism (Mulinari et al., 2009). There is a long history of discourse about Russians, and perhaps to a lesser degree about other post-socialist populations, that resembles the way the colonial South has been described. They have been characterized, for example, as non-European, primitive and dirty (Mulinari et al., 2009; Vuorela, 2009) – not unlike how Finns used to be described in relation to their "dubious" Eastern origins.

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References

Adrian, S.W., 2016. Subversive practices of sperm donation: globalizing Danish sperm, in: Kroløkke, C., Myong, L., Adrian, S.W., Tjørnhøj-Thomsen, T. (Eds.), *Critical Kinship Studies*. Rowman and Littlefield International, London, pp.185–202.

Ahmed, S., 2007. A phenomenology of whiteness. *Feminist Theory* 8(2), 149–168.

Almeling, R., 2011. *Sex Cells: The Medical Market for Eggs and Sperm*. University of California Press, Berkeley.

Andersson, M., 2016. The risk of relatedness: governing kinship in Swedish transnational adoption policy, in: Kroløkke, C., Myong, L., Adrian, S.W., Tjørnhøj-Thomsen, T. (Eds.), *Critical Kinship Studies*. Rowman and Littlefield International, London, pp.203–220.

Bergmann, S., 2011. Fertility tourism: circumventive routes that enable access to reproductive technologies and substances. *Signs* 26(2), 280–289.

Blyth, E., Frith, L., 2015. Access to genetic and biographical history in donor conception: an analysis of recent trends and future possibilities, in: Horsey, K. (Ed.), *Revisiting the Regulation of Human Fertilisation and Embryology*. Routledge, London, pp.136–52.

Blyth, E., Crawshaw, M., Daniels, K., 2004. Policy formation in gamete donation and egg sharing in the UK: a critical appraisal. *Social Science & Medicine* 59, 2617–2626.

Deomampo, D., 2016. *Transnational Reproduction: Race, Kinship, and Commercial Surrogacy in India*. New York University Press, New York.

Dyer, R., 1997. *White*. Routledge, London and New York.

Eriksson, L., 2017. Finland as a late regulator of assisted reproduction: a permissive policy under debate, in: Lie, M., Lykke, N. (Eds.), *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*. Routledge, New York and London, pp.124–135.

ESHRE (European Society of Human Reproduction and Embryology), 2010. Cross-border reproductive care in six European countries. *Human Reproduction* 25(6), 1361–1368.

Franklin, S., 2001. Biologization revisited: kinship theory in the context of the new biologies, in: Franklin, S., McKinnon, S. (Eds.), *Relative Values: Reconfiguring Kinship Studies*. Duke University Press, Durham and London, pp.302–325.

Franklin, S., 2011. Not a flat world: the future of cross-border reproductive care. *Reproductive Biomedicine Online* 23, 814–816.

Franklin, S., 2013. *Biological Relatives: IVF, Stem Cells, and the Future of Kinship*. Duke University Press, Durham and London.

Franklin, S., McKinnon, S. (Eds.), 2001. *Relative Values: Reconfiguring Kinship Studies*. Duke University Press, Durham and London.

Gunnarsson Payne, J., 2016. Mattering kinship: inheritance, biology and egg donation, between genetics and epigenetics, in: Kroløkke, C., Myong, L., Adrian, S.W., Tjørnhøj-Thomsen, T. (Eds.), *Critical Kinship Studies*. Rowman and Littlefield International, London, pp.33–48.

Haimes, E., Timms, N., 1985. *Adoption, Identity and Social Policy: The Search for Distant Relatives*. Gower, Aldershot.

Harbers, H., Mol, A., Stollmeyer, A., 2002. Food matters: arguments for an ethnography of daily care. *Theory, Culture & Society* 19(5/6), 207–226.

Holmes, D.R., Marcus, G.E., 2008. Collaboration today and the re-imagination of the classic scene of fieldwork encounter. *Collaborative Anthropologies* 1(1), 81–101.

Hudson, N., Culley, L., Blyth, E., Norton, W., Rapport, F., Pacey, A., 2011. Cross-border reproductive care: a review of literature. *Reproductive Biomedicine Online* 22, 673–685.

Inhorn, M., 2010. "Assisted" motherhood in global Dubai: reproductive tourists and their helpers, in: Maheer, J.M., Chavkin, W. (Eds.), *The Globalization of Motherhood: Deconstructions and Reconstructions of Biology and Care*. Routledge, New York, pp.180–202.

Isaksson, P., 2001. *Kumma kuvajainen: Rasismi rotututkimuksessa, rotuteorioiden saamelaiset ja suomalainen fyysinen antropologia*. Kusannut Pantsi, Jyväskylä.

Kemiläinen, A., 1998. *Finns in the Shadow of the "Aryans": Race Theories and Racism*. SHS, Helsinki.

Kroløkke, C., 2017. Destination Spain: negotiating nationality and fertility when travelling for eggs, in: Lie, M., Lykke, N. (Eds.), *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*. Routledge, New York and London, pp.61–71.

Kroløkke, C., Myong, L., Adrian, S.W., Tjørnhøj-Thomsen, T. (Eds.), 2016. *Critical Kinship Studies*. Rowman and Littlefield International, London.

Magnussen, J., Vrangbæk, K., Saltman, R.B., 2009. *Nordic Health Care Systems: Recent Reforms and Current Policy Challenges*. Open University Press, London.

Mulinari, D., Keskinen, S., Irni, S., Tuori, S., 2009. Introduction: postcolonialism and the Nordic models of welfare and gender, in: Keskinen, S., Tuori, S., Irni, S., Mulinari, D. (Eds.), *Complying with Colonialism: Gender, Race and Ethnicity in the Nordic Region*. Ashgate, Burlington, pp.1–18.

Namberger, V., 2017. The South African economy of egg donation: looking at the bioeconomic side of normalization, in: Lie, M., Lykke, N. (Eds.), *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*. Routledge, New York and London, pp.72–84.

Nash, C., 2003. They're family! Cultural geographies of relatedness in popular genealogy, in: Ahmed, S., Castañeda, C., Fortie, A.-M. (Eds.), *Uprooting/Regroundings: Questions of Home and Migration*. Berg, Oxford, pp.179–203.

National Institute of Health and Welfare, 2017. *Statistics on Assisted Fertility Treatments 2015–2016*. Statistics Finland, Helsinki.

Oikkonen, V., 2017. *Population Genetics and Belonging: A Cultural Analysis of Genetic Ancestry.* Palgrave Macmillan, Basingstoke.

Ong, A., Collier S. (Eds.), 2005. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Blackwell, Oxford.

Smietana, M., 2017. "Families like we'd always known"? Spanish gay fathers' normalization narratives in transnational surrogacy, in: Lie, M., Lykke, N. (Eds.), *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*. Routledge, New York and London, pp.49–60.

Speier, A., 2016. *Fertility Holidays: IVF Tourism and the Reproduction of Whiteness*. New York University Press, New York.

Thompson, C., 2005. *Making Parents: The Ontological Choreography of Reproductive Technologies.* MIT Press, Cambridge and London.

Thompson, C., 2006. Race science. *Theory, Culture & Society* 23(2/3), 547–549.

Thompson, C., 2009. Skin tone and the persistence of biological race in egg donation for assisted reproduction, in: Glenn, E.N. (Ed.), *Shades of Difference: Why Skin Color Matters*. Stanford University Press, Stanford, pp.131–147.

Thompson, C., 2011. Medical migrations afterword: science as a vacation? *Body & Society* 17(2/3), 205–213.

Van Hoof, W., Pennings, G., De Sutter, P., 2015. Cross-border reproductive care for law evasion: a qualitative study into the experiences and moral perspectives of French women who

go to Belgium for treatment with donor sperm. *Social Science & Medicine* 124, 391–397.

Vora, K., Iyengar, M.M., 2017. Citizen, subject, property: Indian surrogacy and the global fertility market, in: Lie, M., Lykke, N. (Eds.), *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*. Routledge, New York and London, pp.25–36.

Vuolajärvi, N., 2014. Rotu etnisten suhteiden tutkimuksessa, in: Irni, S., Meskus, M., Oikkonen, V. (Eds.), *Muokattu elämä: Teknotiede, sukupuoli ja materiaalisuus*. Vastapaino, Tampere, pp.264–301.

Vuorela, U., 2009. Colonial complicity: the postcolonial in a Nordic context, in: Keskinen, S., Tuori, S., Irni, S., Mulinari, D. (Eds.), *Complying with Colonialism: Gender, Race and Ethnicity in the Nordic Region*. Ashgate, Burlington, pp.19–34.

Waldby, C., 2012. *Clinical Labor: Tissue Donors and Research Subjects in the Global Bioeconomy*. Duke University Press, Durham.

Whitmarsh, I., Jones D.S. (Eds.), (2010). *What's the Use of Race? Modern Governance and the Biology of Difference*. MIT Press, Cambridge.